

Lincolnshire Safeguarding Children Partnership

Serious Incident Review Guidance

Rapid Reviews

Local Child Safeguarding Practice Reviews

*"We have a system in England that is rightly considered one of the most effective in the world of safeguarding vulnerable children. It is a system in which we can have confidence and practitioners within it should feel confident about their skills and expertise. Equally, no system and no practitioner can be perfect and there needs to be sufficient embedded humility to ensure there is the capacity and capability for learning and improvement."* (National Panel, 2019)

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Introduction

This document sets out the arrangements by which Lincolnshire Safeguarding Children Partnership (LSCP) will determine when to trigger a Rapid Review process or another appropriate alternative case review process. It highlights its statutory duties, overall process for conducting a local Child Safeguarding Practice Review (CSPR) and how the Partnership will commission such work. The core process it will utilise for all case reviews is set out in the document.

It should also be noted that the LSCP is concerned with reviews of significant cases, some of which will become a CSPRs: others may become reviews commissioned by the LSCP when potential learning is identified. Where learning is identified but the case does not meet serious harm criteria alternative processes will be considered. This will be identified within the document.

The CSPR process will be flexible on methodology depending on the nature and complexity of a case

Local Authority Notifications – Process 1

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| 16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017) states:  Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if –   1. the child dies or is seriously harmed in the local authorities area, or 2. while normally resident in the local authority's area, the child dies or is seriously harmed outside England. |

The local authority must notify any event that meets the above criteria to the Child Safeguarding Practice Review Panel. They should do so within five working days of becoming aware that the incident has occurred. The local authority should also report the event to the safeguarding partners in their area (and in other areas if appropriate) within five working days.

The local authority must also notify the Secretary of State and Ofsted where a child in care has died, whether or not abuse or neglect is known or suspected.

*(Working Together 2018 – Chapter 4, para. 12-13)*

How to refer a case for review – Process 2

To support all partners to recognise and refer cases, the LSCP has developed a single case referral form (Appendix A). This form allows a partner to outline the case and propose the process they feel is required from either a:

1. Rapid Review – potentially leading to a Child Safeguarding Practice Review

2. Learning Review – potentially leading to a multi or single agency review of practice

This form is submitted to the LSCP Business Manager (via [lscp@lincolnshire.gov.uk](mailto:lscp@lincolnshire.gov.uk)) who will present the request to the Serious Incident Review Group (SIRG) who will determine the most appropriate learning pathway (see Appendix B). This will be based on guidance and definitions provided by Working Together 2018 in relation to serious harm and notifiable incidents. All referrals and decisions will be reported to the SIRG who will act as a scrutineer to the pathways selected. However, ultimate authority and decision making for commencing rapid reviews will rest with the Assurance Executive.

Once the SIRG has selected an appropriate pathway the case will progress within set timescales (see Appendix C for an overview). The referrer will be updated as to the progress of the case if taken forward into any form of learning review. It is vital that those making referrals ensure that all relevant information is included at the time of the initial referral to prevent any unnecessary delays in decision making.

It is expected that each Safeguarding Lead Officer (SLO) authorises its own individual agency referrals before they are submitted to the LSCP team. This is to ensure that all referrals have been sufficiently considered by a senior manager before the learning review pathway is triggered. This process is for cases meeting specific criteria, which will be explored in later sections, and SLOs should ensure it is only these cases that are referred for the attention of the partnership. For example, those that are notifiable incidents, cases of “serious harm”, unresolved escalation cases and cases where a multi-agency practice review is necessary to identify lessons for practice.

The purpose of the LSCP Learning Review process is identified within Working Together 2018 as:

*“… to identify improvements to be made to safeguard and promote the welfare of children…Reviews should seek to prevent or reduce the risk of recurrence of similar incidents.” [[1]](#footnote-1)*

Chapter 1: Serious Incident Notification

Working Together 2018 identifies that where a case is a “serious child safeguarding case” then partners must make arrangements to identify, commission and oversee arrangements for that review process. These cases are identified within the statutory guidance as distinct from our day to day practice by certain terms.

*"Serious child safeguarding cases are those in which:*

* *abuse or neglect of a child is known or suspected* **and**
* *the child has died or been seriously harmed"* (WT18, Chpt. 4, para. 10)

Firstly, “serious harm”, this term is defined as:

*“… serious and/or long-term impairment of a child’s mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health…judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred.”* (WT18, p.85, para. 11)

Secondly, *"known or suspected".* The CSPR Panel: Practice Guidance April 2019 confirms that "*Notifications must always be made if abuse or neglect is a cause of, or a contributory factor to the serious incident, or where this is suspected."* (p.13) however it is recognised that it is sometimes *"only through the rapid review that a judgement can be made about the strength of the relationship between the serious incident and abuse or neglect"* (p.13).

The duty to notify serious safeguarding incidents to the Child Safeguarding Practice Review Panel[[2]](#footnote-2) rests with the local authority. A Rapid Review will automatically be triggered by the local authority completing a notification to the National Panel within five days of becoming aware of a serious safeguarding incident which they assess meets the criteria[[3]](#footnote-3) for the duty to notify. Case Notification and the Rapid Review process is explained further in the next chapter.

If local partners identify a case where serious harm or death has occurred and abuse and or neglect is known or suspected, then they should refer the case to the SIRG and consideration will be given to whether or not a learning or rapid review may be appropriate.

Meeting the criteria does not mean that safeguarding partners must automatically carry out a local CSPR. If the learning identified is already known about and changes in practice are in progress, then safeguarding partners may decide not to carry out a review. They may, also initiate a different type of learning review. Conversely some cases may not meet the definition of a ‘serious child safeguarding case’ but nevertheless raise issues of importance to the local area, e.g. good practice learning opportunity, so safeguarding partners may choose to initiate a local Child Safeguarding Practice Review.

A referral to the LSCP can trigger a range of 4 different responses. The information below aims to help clarify which pathway may be used and when.

Rapid Review

Where SIRG have received a notification from a partner, who is not the local authority, they will consider if the criteria is met and if a local CSPR is required. Therefore, not every case referred to the LSCP will lead to a Rapid Review as these are held only for those cases meeting this distinct criteria. If SIRG agree that the criteria is met then a recommendation will be escalated to the Assurance Executive on the Recommendation to Review Form (Appendix D). If the Assurance Executive agrees with the recommendation, a rapid review will take place to determine if a local CSPR is needed. In these cases, a Rapid Review Report will be returned to the National Panel within 15 working days of the referral being received.

Notification to the National Panel is made via the online form available at <https://www.gov.uk/guidance/report-a-serious-child-safeguarding-incident>

A Learning Review

If the threshold for a CSPR (or Rapid Review) is not met or a decision is taken that learning is already embedded so a full CSPR is not necessary, then alternative learning processes or responses can be considered.

A learning review will be considered by the SIRG when Rapid Review or CSPR criteria is not met. They will review the referral against the following criteria to determine if a practice review is required:

* potential for multi-agency learning
* potential learning is unique or significant
* positive multi-agency working and an opportunity to learn from successful outcomes

The form of this review will be determined based on the individual case needs and proportionate for the learning involved. For example, a desk top review may be proposed for those cases where learning is limited to short periods of time and less complex case elements. In contrast for complex cross border cases then a more complex professional de-brief process may be utilised. Critical Moment Reviews may also be taken forward with the original participants in the case to review identified aspects of the case as part a reflective practice session chaired by an independent facilitator or member of SIRG.

Single Agency Review

Where the issue relates to a single agency process and system then that agency may be tasked to take forward an appropriate review and report back its findings to SIRG. This could utilise existing learning processes within agencies such as Initial Fact Finds (IFF) or Root Cause Analysis reports.

In each instance, the appropriate learning response will be proposed by the SIRG and monitored to ensure the learning review is timely and lessons learnt are cascaded across the partnership.

No Further Action

In some cases, it may be appropriate to take no further action with a case referral. If individual agencies have reviewed their cases before referring them in, then the number of cases being identified by SIRG for no further action should be reduced. However, there still may be occasions where a referral is received and the SIRG do not see that any further action is required, having heard all the information from agencies. For example, if a case reflects learning from a recently commenced review it may be determined that there is no purpose to reviewing the case in addition. Similarly, if a review has just concluded and the learning has not yet been shared then it may be determined that the lessons have been identified but action has not yet been implemented.

If agencies are dissatisfied with the decision reached by the SIRG then they may challenge this through the escalation process[[4]](#footnote-4).

Chapter 2: Rapid Review Process

If the safeguarding partners determine that a Rapid Review is required, then the SIRG should promptly undertake a Rapid Review of the case. This will be for those cases which meet the threshold of a Notifiable Serious Child Safeguarding Incident or the Assurance Executive has taken a decision that a Rapid Review is the most appropriate way forward. The review should aim to:

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* Gather the facts about the case as far as they can be readily established at the time.
* Discuss whether there is any immediate action needed to ensure children’s safety and share learning appropriately.
* Consider the potential for identifying improvements to safeguard and promote the welfare of children.
* Decide what steps they should take next, including whether or not to undertake a Child Safeguarding Practice Review.

All partners/agencies that had knowledge of the child will be required to contribute to a Rapid Review.

Within 24 hours of being notified of the decision to commence a Rapid Review, the LSCP Business Manager will communicate to the members of SIRG that a Rapid Review has been triggered. With 48 hours, a Terms of Reference meeting will be convened and attended by the SLOs for the three key statutory partners, LSCP SIRG Chair, Business manager and Legal adviser. This meeting will confirm the scope of the review including the timeframe, key individuals and other partners who may have a vital role to play and how they will contribute to the review. The dates for the Rapid Review Panel meetings will also be agreed. The Terms of Reference template (Appendix E) will then be distributed to SIRG members (and any identified others) along with the chronology template (Appendix F) to be completed and returned by a date specified in the TOR.

A single agency chronology (Appendix F) should be submitted containing detailed supporting analysis of practice and systems. The chronology should only include relevant events to the incident and not be a log of an agency's every contact with the child or family.

All agencies should secure all records/files in relation to the case through safeguarding leads/managers in their service area and a process agreed to ensure access is appropriate to those professionals involved in on-going service delivery to the child/carers.

On receipt of all the completed chronologies, the LSCP Business Support team will collate and combine the returns into one master chronology. This single document will form the basis of the review and the report. The master chronology will be shared ahead of the panel meetings to the core membership of the Rapid Review Panel which will consist of the three representatives for the key statutory partners and advisers as follows:

* Lincolnshire Children's Services – SLO
* Lincolnshire Police – SCR Author
* Lincolnshire CCG – Designate Doctor
* LSCP SIRG Chair
* LSCP Legal Advisor
* LSCP Business Manager

In addition there may be occasions where the Rapid Review Panel invite a member of SIRG whose agency does not have a significant role in the case under review to act as a 'critical friend' to the Rapid Review panel to provide additional challenge.

Additional attendees may be co-opted onto the Rapid Review Panel for all or part of the review depending on the nature of the case and the level of their agency involvement with the child or family. For example, schools who will often see children who are the subject of the review for long periods of time can often give a personal pen portrait of the child's experiences of life.

Ahead of the Rapid Review Panel meeting the LSCP Business Manager will start to populate the report with the factual information available, drawing on the agreed TOR and information in the chronology.

The Rapid Review Panel meeting will meet across a minimum of two days depending on the complexity and length of the review. The Rapid Review Panel will review the case and consider where multi agency practice worked well and where developments could have improved outcomes. Rapid Review Panel members will utilise the review criteria laid out in the national CSPR Practice Guidance to consider the case and identify if the need for a local or national CSPR is evident.

*"Safeguarding partners should also consider… ..that rigorous and comprehensive rapid reviews can offer a new mechanism through which the key learning may be identified and disseminated quickly within a matter of weeks. A well conducted rapid review can form the basis of a… …local child safeguarding practice review and, in some cases, may avoid the need for an additional lengthy process with limited additional learning."* (CSPR: Practice Guidance, p. 14, April 2019)

The Rapid Review Report

On completion of the Rapid Review Panel, the three representatives for the key statutory partners should agree the Rapid Review report and the LSCP Business Manager should share this with the Assurance Executive for final sign off. On the fifteenth day after the notification, the LSCP Business Manager will submit the Rapid Review report to the National Panel. The Rapid Review Report template can be found in Appendix G.

In relevant cases the Coroner will be notified about the decision to undertake a rapid review by the LSCP legal adviser.

Once the Rapid review report has been submitted, the recommendations are collated at SIRG into a working action plan. The action plan will be regularly reviewed, and its impact evaluated using existing LSCP processes via the SIRG. SIRG representatives are responsible for ensuring that any learning from the Rapid Review is disseminated through their own organisations as appropriate.

The three outcomes from the above Rapid Review process are:

* Agree and deliver Rapid Review action plan
* Recommendation for a local CSPR
* Recommendation for a national CSPR

Decision making on initiating local CSPRs

The criteria which the local safeguarding partners must take into account when deciding whether to initiate a local Child Safeguarding Practice Review include whether the case:

* Highlights improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
* Highlights recurrent themes in the safeguarding and promotion of the welfare of children.
* Highlights two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.
* Is one which the National Panel have considered and concluded a local review may be appropriate.

Safeguarding partners should also have regard to the following circumstances:

* Where the safeguarding partners have cause for concern about actions of a single agency.
* Where there has been no agency involvement and this gives the safeguarding partners cause for concern.
* Where more than one local authority, police area, or clinical commissioning group is involved, including in cases where families have moved around.
* Where cases may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

(Working Together 2018, p.87-88)

Recommendation for a National CSPR

Where a case may raise issues which are complex or of national importance, the report may recommend that a national CPSR may be appropriate. They may also do this if, during the course of a local CSPR, new information comes to light which suggests that a national review may be appropriate. Further details about a national CSPR are included below in Chapter 4.

Scrutiny & Challenge

Under Working Together (2018), the criteria for local CSPR offers greater flexibility for partners to consider how learning is best generated within a new safeguarding arrangement. External scrutiny of this decision making is offered by the National Panel through the submission of any Rapid Review Reports. If the National Panel's view is contrary to the decision of the Assurance Executive on whether or not to undertake a local CSPR, then the Assurance Executive would consider this formal feedback.

LSCP has built in a process to support internal scrutiny by including the role of the 'critical friend' in the Rapid Review Process. Where appropriate, the critical friend will be a member of the SIRG who has independence from the case and will offer constructive challenge to partners completing the Rapid Review.

Where new information is brought to the attention of the SIRG or the LSCP Business Manager, consideration will be given as to whether this would alter the decision on whether to review or not and the matter may be referred back to SIRG for further consideration.

Chapter 3: The Purpose of a local Child Safeguarding Practice Review (CSPR)

The key aim of any review remains as set out in the following legislation/guidance:

* Working Together 2018[[5]](#footnote-5)
* Domestic Violence, Crime and Victims Act (2004)[[6]](#footnote-6)
* Child Safeguarding Practice Review Panel: Practice Guidance 2019[[7]](#footnote-7)

*"Under Working Together 2018 there is greater discretion as to when a local CSPR should take place and who does it. This will create greater flexibility in designing a single review mechanism, which still meets a variety of specific obligations."* (CSPR: Practice Guidance, page 19, April 2019)

In order for a local CSPR to be effective and in line with the above guidance it should be conducted in a way which:

* Recognises the complex circumstances in which professionals work together to safeguard children.
* Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
* Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
* Is transparent about the way data is collected and analysed.
* Makes use of relevant research and case evidence to inform the findings.

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Therefore, the focus will be on understanding practice and not to hold individuals or organisations to account. There are other processes that exist to undertake that role, such as employment law and disciplinary procedures, and these should be used when that is sought. These processes can be run in parallel or subsequent to one another and decisions regarding the appropriate timetabling will be made on a case by case basis.

Working Together 2018 and the National Panel Guidance[[8]](#footnote-8) outline the expectations for reviews and timescales. The expectation of the LSCP is that this report and learning is available no later than 6 months after the decision to initiate a review is made. This is to ensure that all learning remains relevant to current practice. Therefore, the partnership will endeavour to produce a concluded review within 6 months.

There may be challenges to this, such as criminal proceedings or Coronial processes. Should these impact on the review process, then steps will be taken to share information and continue the review as far as is possible without undermining these other processes nor limiting the review itself. Any early identified actions will be commenced to avoid delay where service / multi agency working practices can be improved.

Conducting the local CSPR

A Chair and/or Author (who may be independent) will be appointed by the LSCP Business Manager

The SIRG will delegate their authority for the conduct of the local CSPR to the local CSPR Sub-group who will, together with the Chair/Author:

* agree terms of reference
* Create a living action plan to be reviewed during the local CSPR
* Quality assure the local CSPR process
* Co-opt professionals onto to the local CSPR Sub Group as appropriate.
* Ratify the report for final sign off by the Assurance Executive

The sub group membership will be determined on a case by case basis dependent on the nature and context of the case. However the membership must include representation from each of the three key statutory partners as a minimum.

As part of the terms of reference, and their duty to ensure that the local CSPR is of satisfactory quality, the local CSPR Subgroup should ensure that:

* practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
* families, including surviving children, are invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process91. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

In addition, the TOR should also consider the following:

* Communication lead - Contact point for responding to media interest about the review in conjunction with the LSCP Media Engagement Team.
* Criminal trial process (where appropriate) – undertaken by Legal adviser to LSCP
* Coroner (where appropriate) – must be undertaken by Legal adviser to LSCP

The review sub group chair should as far as possible ensure that the review process is a learning exercise in itself for all those involved in the case.

## Chair and/or Author

Working Together 2018 does not specify the need for an independent Chair for a CSPR so this will depend on the complexity of the case, the review model selected and other local considerations. If an independent chair/author is appointed their name/s should be shared with the National Panel. If the National panel offer advice and/or guidance on the appointment of an independent Chair or Author, then this will be taken into consideration.

The Chair/author should be an appropriately experienced individual who is not directly associated with the case under review.

Consideration should be given to the skills and expertise required to effectively chair a CSPR and/or author in relation to the nature of the specific case in focus. The identified individual should have, as a minimum, the following appropriate core skills:

* Strong leadership and ability to motivate others.
* Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics.
* Collaborative problem solving experience and knowledge of participative approaches.
* Ability to find and evaluate best practice.
* Good analytical skills and ability to manage quantitative and qualitative data.
* Knowledge of safeguarding
* Ability to write for a wide audience.
* An understanding of the complexity of the health and social care arrangements and an awareness of issues which are complex or of national importance such that a national review may be appropriate.

Methodology

*"The review should be proportionate to the circumstances of the case, focus on potential learning and establish and explain the reasons why the events occurred as they did" (WT18, p91)*

The local CSPR Sub group should agree with their Chair/Author the method by which the review should be conducted, taking into account the principles of the systems methodology[[9]](#footnote-9). The methodology should provide a way of looking at and analysing frontline practice as well as organisational structures and learning. The methodology should be able to reach recommendations that will improve outcomes for children. All reviews should reflect the child’s perspective and the family context.

The local CSPR sub group Chair will establish an agreed timetable of review sub group meetings in accordance with the required timescales of the review and set specific parameters, including timescales for the completion of chronologies, conversations and any other learning event which includes further exploration of practitioners’ views.

The LSCP Business Manager will maintain contact with any other parallel review or investigation processes (as appropriate in consultation with the legal adviser to LSCP) to ensure that any coordination and joint commissioning arrangements are effective.

Where there is an on-going criminal investigation, the local CSPR sub group Chair/Author (as appropriate in consultation with the legal adviser to LSCP) will ensure that early and regular contact is made with the senior investigating officer to ensure appropriate processes are being followed. This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be a potential witness or even defendants in a future criminal trial.

Involvement of family members, friends, and other support networks

Family members can offer a unique perspective into how the delivery of services and involvement of agencies were viewed and responded to. It is essential that the review sub group have opportunities to listen to family experiences and perspectives and that these contribute meaningfully to the final report.

Family members can include:

* Siblings
* Parents
* Carers
* Grandparents
* Other significant family members identified from the Family Association Network/ Genogram.

Any others within the wider network who have a meaningful contribution to make to the review should also be considered. This could be friends, faith groups or employers.

As a minimum, family members should:

* Be notified of the review process, what that means for them and how they can access support – including impact of media coverage.
* Agree the level and frequency of contact with family members to ensure they are kept informed.
* Be supported to contribute to the review process – either in writing, by meeting with the local CSPR Chair/Author, sharing views via a third party or by other means identified by the review sub group or family member.
* Be included in feedback about the learning identified by the local CSPR.
* Be informed and prepared for the publication of the report in a timely manner – again including the likelihood of media interest.
* Be provided with an embargoed, confidential copy of the report ahead of publication for information.

The final overview report

The local CSPR overview report brings together the learning and themes identified from the review and will analyse and comment on the effectiveness of practice and the systems used to safeguard and promote the welfare of the child.

The local CSPR Sub-group Chair has responsibility for collating the report and the final report should include:

* a summary of any recommended improvements to be made by persons in the area to safeguard and promote the welfare of children
* an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report
* recommendations that are clear on what is required of relevant agencies and others collectively and individually, and by when, and focussed on improving outcomes for children.

The report should also:

* Have clearly framed questions that the review seeks to answer.
* Have a short and succinct executive summary.
* State clearly learning points and steps for learning.
* Be written in such a way that it can be published with minimal redaction.

The local CSPR overview report should firstly be presented to the review sub group. This provides an opportunity for the Chair and review sub group to quality assure the document, reference the identified learning and ensure an opportunity for the findings to be challenged where necessary.

It is the responsibility of the LSCP Business Manager to add the learning points from the review into the living action plan. It will be the responsibility of the SIRG to identify and agree how practice challenges or recommendations from the local CSPR will be responded to and what action is needed by individual agencies or from a multi-agency perspective.

Once agreed the Author/Chair of the review sub group should present the report to the Assurance Executive for final sign off. The report will then be presented to the next Strategic Management Group meeting for information purposes.

Once the local CSPR report and action plan have been agreed, the report will be endorsed and signed off by the LSCP Assurance Executive. The action plan will be regularly reviewed, and its impact evaluated using existing LSCP processes via the SIRG.

The findings from any local CSPR should be reported in the LSCP Annual Report and what actions it has taken or intends to take in relation to those findings. Where the LSCP decides not to implement an action, then the Annual Report must state the reason for that decision.

Communication Publication Strategy

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The LSCP Business Manager, involving the LSCP Communication Officer, will lead on the development of the publication strategy for the local CSPR in consultation with the three statutory partners. Discussions about publication will be held with the individual(s), their family or carers (where appropriate) and key partners. Only in exceptional circumstances will a local CSPR not be published and this decision will be made by the Assurance Executive.

A Publication Strategy Meeting will be held with the three statutory partners and other relevant agencies, including their communication leads. Since the Local Authority is the lead agency, media and communication issues will usually be co-ordinated by the LSCP Communications Officer who sits within the Council’s communications team. This will be done in collaboration with the communications teams of the other agencies involved, alongside agreed representatives of the partnership.

Ahead of publication arrangements will be made by the LSCP Business Manager to upload the report onto the LSCP web site and release a statement informing partners and the National Panel. The report will be shared with the National Panel seven days prior to publication.

Learning from local CSPRs

The value of local CSPRs is in the learning derived from them. As much effort should be spent on acting on recommendations as on conducting the actual review. Recommendations should be SMART: Specific, Measurable, Achievable, Realistic, and Timed.

The following should help to secure maximum benefit from the review:

* Conduct the review in such a way that the process is a learning exercise.
* Consider what information needs to be disseminated (how and to whom) in the light of a review.
* Be prepared to communicate both examples of good practice and areas where change to practice is required.
* Focus recommendations on a small number of key areas with specific and achievable proposals for change and intended outcomes.
* Ensure robust monitoring of the resultant action plan to ensure identified changes/improvements are implemented and embedded.
* Communicate with the local community and media to raise awareness of the positive work of services working with children where appropriate.
* Make sure staff and their representatives understand what can be expected in the event of a local CSPR (see Appendix I).

Chapter 4: The National Child Safeguarding Practice Review Panel

The purpose of the National Panel is to operate independently from government and local areas to identify changes that will create an improved practice system for children and families that reduces child abuse and neglect. The National Panel became operational in June 2018 and is responsible for determining whether or not the criteria for a national CSPR are met.

Accordingly, on receipt of a rapid review report, the National Panel must decide whether it is appropriate to commission a national CSPR of the case or cases. They must consider the criteria below:

* Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
* Raises or may raise issues requiring legislative change or changes to guidance issued under or further to any enactment.
* Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children.

The National Panel should also have regard to the following circumstances:

* Significant harm or death to a child educated otherwise than at school.
* Where a child is seriously harmed or dies while in the care of a local authority, or while on (or recently removed from) a child protection plan.
* Cases which involve a range of types of abuse.
* Where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings.

The National Panel will also consider a range of evidence when considering their decision, including inspection reports, other reports and research. There will be need for a dialogue in many cases between local safeguarding partners and the National Panel to support decision making. Information should be shared with the National Panel on request.

The National Panel should inform the relevant safeguarding partners promptly if they consider:

* Further information is required before a decision can be made by the National Panel.
* A national CSPR is appropriate, setting out rationale for decision making (including to families) and next steps.

The National Panel will inform the Secretary of State when a decision is made to carry out a national CSPR.

The National Panel will discuss with the LSCP the potential scope and methodology of the national CSPR and how they will engage with them throughout.

There will be instances where a local CSPR has been carried out that is relevant to a national CSPR or a local CSPR has not been carried out, but the National Panel feel that such a review would be helpful to a national CSPR sometime in the future. In these circumstances the National Panel will engage with the LSCP to agree conduct of national CSPRs.

Links to Other processes that may affect local or national CSPRs

There may be a criminal investigation, a coroner’s investigation and/or professional body disciplinary procedures running alongside a local or national review. The National Panel and local safeguarding partners will agree a clear process of how they will work with other processes including Domestic Homicide Reviews, Safeguarding Adult Reviews or Mental Health Homicide Reviews, including joint reviews.

When undertaking any CSPR all relevant areas of enquiry that need to be addressed should be established at the outset to reduce potential for duplication for families and staff.

Any CSPR will need to take account of a coronial enquiry and/or any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.

Coroners

Coroners are independent judicial office holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause and deaths in custody, or otherwise in state detention, which are reported to them. The Coroner may have specific questions arising from the death of a child/and or adult at risk. These are likely to fall within one of the following categories:

* Where there is an obvious and serious failing by one or more organisations.
* Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation.
* Where a death has occurred and there are concerns for others in the same household or other setting.
* The Coroner or his or her officers identify deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions.

Please note: Any correspondence with the Coroner must go through the LSCP Legal Advisor.

Police Investigations

Where any learning review/Rapid Review or CSPR is taken forward and there are on-going police processes it is important that information is shared in a timely fashion. This includes if the review has concluded and new information is uncovered in on-going police investigations.

The LSCP Legal Advisor will engage with and liaise with the leads for other legal processes in relation to review work.

Escalation Procedure

Where a professional is unsatisfied with decisions or processes in relation to reviews then they should utilise the LSCP Professional Resolution and Escalation Protocol.[[10]](#footnote-10) Complaints raised against the decision of SIRG or the Review Sub-Group acting on SIRG's behalf will be heard by the Assurance Executive and the LSCP Independent Chair.

Complaints raised by a member of the public about a decision or review will be managed through the Lincolnshire County Council Corporate and Statutory Complaints Procedure.[[11]](#footnote-11)

The LSCP Business Manager will ensure that a record is kept of complaints received, responded to and those referred to partner agencies. Complaints and copies of responses will be securely retained in accordance with the principles of data protection legislation and the LSCP retention policy.

Media Interest Referral

At times, partners may become aware of an incident or case that they assess has the potential to attract local or national media interest. To ensure that the LSCP and relevant partners are aware of the case and can prepare accordingly, the Single Case Referral form (Appendix A) should be completed and submitted to the LSCP Business Manager. On receipt of the form, the LSCP Business Manager will circulate the form to SIRG and provide an update to the Assurance Executive, Independent Chair and the appropriate Media Officers. The LSCP and Media Officer will continue to monitor any media interest.

Appendices

|  |  |  |
| --- | --- | --- |
| Appendix A | Single Referral Form |  |
| Appendix B | Referral Process Chart | Below |
| Appendix C | Rapid Review Process Map | Below |
| Appendix D | Recommendations from SIRG to Assurance Executive |  |
| Appendix E | Terms Of Reference for Rapid Review |  |
| Appendix F | Chronology Template |  |
| Appendix G | Rapid Review Report Template |  |
| Appendix H | Rapid Review – 7 Minute Briefing |  |
| Appendix I | Local CSPR – 7 Minute Briefing |  |

Appendix A – Serious Incident Notification Form (SINF)

|  |
| --- |
| Partner Notification of a Child Safeguarding Incident (SINF) |
| Working Together 2018 (Chpt 4, para 10) identified a serious child safeguarding case as those in which:   * Abuse or neglect of a child is known or suspected and * The child has died or been seriously harmed.   Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. |
| Referring a case for a multi-agency learning review |
| * There are cases that do not meet the criteria for a serious child safeguarding incident nor a notifiable incident however are felt to hold the potential for valuable lessons for practice. For example, uncommon and complex circumstances where professionals may have struggled to effectively managed the risk or work collaboratively to address concerns, or where there is perceived to have been a 'near miss' in relation to serious harm. * The purpose of referring these cases is to create a learning opportunity for the professionals involved to reflect on what worked well, what caused some concerns and identify what could be done to improve experiences and outcomes moving forward. * Similarly, this referral could be to share a good practice case where professionals were able to effectively collaborate and co-ordinate practice to the benefit of the child or family. In these instances you may be seeking to showcase a method of working that celebrates effective partnership. |
| Considering a case for a multi-agency learning review |
| In considering a case for a learning review, SIRG will consider the following criteria:   * There is multi-agency involvement with the child or family * The review will or may highlight improvements needed to safeguard and promote the welfare of children * The review will or may highlight recurrent themes in the safeguarding or promotion of the welfare of children. * The review will or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children. * The case raises issues of importance in relation to Lincolnshire. |

**Professionals should discuss the case with the agency Senior Liaison Officer to help formulate the rationale. Submission of this form should only be by your LSCP Senior Liaison Officer (SLO) or their nominated deputy. Once completed, forms should be submitted to**[lscp@lincolnshire.gov.uk](mailto:lscp@lincolnshire.gov.uk) **For advice on completion this form, please contact the LSCP Business Manager,** [**Stacey Waller**](mailto:Stacey.waller@lincolnshire.gov.uk)**.**

|  |  |
| --- | --- |
| 1. **Child details** | |
| Name: |  |
| Date of Birth: |  |
| Address: |  |
| NHS Number (if know): |  |
| Gender: |  |
| Ethnicity: |  |
| Disability: |  |
| Education Provision: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **The Child's Family/Network** | | | | |
| Relationship to child | Name | Date of Birth | Address | NHS Number |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| 1. **Professional network (evidence of multi-agency working)** | |
| Agency | Nature of involvement and/or intervention. |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| 1. **Details about the incident / near miss**   What happened? Brief description of the event triggering the referral, including key dates/locations. Why is this case being referred at this time? Include details of any immediate action take to ensure child/siblings safety. |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Why are you making the referral?**   Please explain why you think this meets the criteria for a multi-agency learning review / partner notification. | | | |
| **Partner Notification of Serious Incident** |  | **Consideration for learning review** |  |
|  | | | |

|  |  |
| --- | --- |
| 1. **Referral Details** | |
| Date of notification to LSCP |  |
| Name of SLO / Agency |  |
| Tel Number |  |

Appendix B – Referral Process Chart

NB. The Local Authority has the capacity and a duty to notify the National Panel of Serious Child Safeguarding Incidents independent of this process

Criteria for referral from partners:

Media Interest

Learning Review

Rapid Review

Partner submits a referral form to LSCP

(Appendix A)

Agenda on next appropriate SIRG

Call for limited agency information / summary of involvement

LSCP monitor media interest

Update provided to SIRG / AE / Independent Chair and Media Officer

NFA / Requires more information

LSCP Business Manager Triages Referral

Media Interest

Learning Reviews:

1. LSCP directly facilitate learning review
2. Agency facilitated learning review with SIRG receiving the learning
3. Single agency review

Learning Review

AE decision on Rapid Review

Recommendation to AE for Rapid Review

NFA

Appendix C - Rapid Review Process Map

Appendix D – Recommendations from SIRG to AE

|  |  |
| --- | --- |
| Notified by (Agency) |  |
| Date Discussed at SIRG |  |

|  |  |
| --- | --- |
| Details of the child (please replicate for any additional children) | |
| Child's full name |  |
| Date of birth |  |
| Date of death (if applicable) |  |
| Gender |  |
| Ethnicity |  |
| Disability |  |
| Legal status at the time of the incident |  |
| If on a Child Protection plan – start date and category. |  |
| Other Services involved at the time or prior to the incident (include 'from' and 'to' dates) |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Reason for notification (select one) | | Death / Serious Harm | | | Neglect / Abuse |
| Date of the incident (date of the event that triggered this notification) | |  | | | |
| Characteristics of the incident (select all that apply – suspected or actual) | | | | | |
| Abuse - Alcohol | Abuse – Peer – on Peer | | Abuse – Sexual Inter familial | Abuse – Extra Familial | |
| Abuse - Emotional | Abuse – Drugs/Solvents | | Abuse - Physical: Female genital mutilation | Abuse - Physical: Self-harm | |
| Abuse - Online | Criminal Exploitation – Modern Slavery | | Criminal exploitation - Trafficking | Criminal Exploitation – County Lines | |
| Criminal Exploitation - Other | Bullying | | Child's harmful behaviours | Extremism | |
| Fabricated illness | Filicide (parent kills child) | | Gang violence | Injury | |
| Child exploitation | Knife crime | | Road Traffic Accident | Life-limiting illness (natural causes) | |
| Neglect - longstanding | Neglect - recent | | Serious illness | Sudden Infant death | |
| Shaken baby syndrome | Suicide | | Other | Not yet known | |

|  |
| --- |
| **Incident Outline**. What happened? Details of when and where the incident took place; events leading up to the incident; names of people involved including staff; why the incident happened; other important details. |
|  |
| **What action shave been taken?** Include details of what is being done to safeguard any child at risk from the alleged perpetrator |
|  |
| **Rationale for the recommendation to carry out review** |
| *In coming to the decision to carry out the review, SIRG had due consideration of the following guidance;*  *Working Together 2018, Chapter 4, paragraphs 1-18.*  *Child Safeguarding Practice Review (CSPR) Panel: practice guidance. April 2019*    *It is on the basis of the above information that the SIRG make the recommendation to the Assurance Executive to complete a notification to the National Panel on this serious child safeguarding incident.*  *Should the Assurance Executive agree with this recommendation, SIRG will have 15 days to complete a Rapid Review from the point of the notification. On conclusion of the Rapid Review, a recommendation will be made on the requirement for any further review.*  *Should the Assurance Executive not agree with SIRG then the group would welcome feedback on the decision.* |
| **Assurance Executive Response and rationale** |
| Date of meeting:  Attendees: |

Appendix E – Terms of Reference for Rapid Reviews

# Terms of Reference for the Rapid Review

**Background**

These terms of reference are to meet the requirements for the Child Safeguarding Practice Review Arrangements Rapid Review.

The local authority should report to the Lincolnshire Safeguarding Children Partnership (LSCP) Business Manager, any child safeguarding incidents which they are notifying to the Child Safeguarding Practice Review Panel. They should do this within five working days of becoming aware that the incident has occurred.

A serious incident is defined under Section 16C (1) of the Children's Act 2004 (as amended by the Children and Social Work Act 2017), as when:

* abuse or neglect of a child is known or suspected and
* the child has died or been seriously harmed.

Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health.

**Purpose**

When a serious incident becomes known to the LSCP, the LSCP should coordinate the three key statutory agencies, and relevant partners, undertaking a rapid review of the case.

The aim of the Rapid Review is to enable the three key statutory agencies to:

* Gather the facts about the case, as far as they can be readily established at the time.
* Discuss whether there is an immediate action needed to ensure children's safety and share any learning appropriately.
* Consider the potential for identifying improvements to safeguard and promote the welfare of children.
* Decide what steps they should take next, including whether or not to undertake a Child Safeguarding Practice Review

As soon as the rapid review is completed and signed off by the three statutory partners, the LSCP should send a copy to the Child Safeguarding Practice Review Panel.

The LSCP should share with the National Panel any thoughts on whether the case may raise issues which are complex or of national importance such that a national review may be appropriate, and on whether the LSCP plans to carry out a Local Child Safeguarding Practice Review.

The purpose of the Rapid Review is to enable the Child Safeguarding Practice Review Panel to make a decision on whether to undertake a national child safeguarding practice review.

**Child and other significant others in scope:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Relationship to child** | **DoB** | **Address** | **NHS Number** |
|  |  |  |  |  |
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**Scope Period**

At a meeting of the three statutory partners on INSERT DATE, initial information held by partners was considered and the scope of the review was agreed. Chronologies should focus on the period INSERT FROM AND TO DATES**.** In addition, partners also have a duty to include a summary of any key information that they identify as pertinent to the review from any period prior to this.

**Contributors**

* Children's Services, including Children's Health
* Police
* CCGs plus Health Providers
* Education
* Any other agency with significant involvement with the child and family

**Methodology**

* The LSCP chronology and/or template is to be completed and submitted to the LSCP by **9am on INSERT DATE**.
* **Relevant and significant points** for the period in scope are to be included, on the individuals identified above. This should include what was working well and why, and what the worries were.
* The focus of the review is on **why events happened** and not what happened.
* Post mortem report is to be used where relevant.
* Child's Plan is to be used where relevant.
* The Rapid Review Panel meeting is to be held across two days, on **INSERT DATES**to complete the Rapid Review Report.
* The Rapid Review Panel will establish the key points for the report.

**Reporting**

The Rapid Review Group will feed back to the Significant Incident Review Group (SIRG) and the three key strategic leads for the Local Area, that is the Director of Children's Services representing Lincolnshire County Council, the Chief Nurse representing Lincolnshire Clinical Commissioning Group and the Assistant Chief Constable representing Lincolnshire Police.

The LSCP Business Manager will submit the Rapid Review Report to the National Panel on **INSERT DATE.**

**Membership**

| **Rapid Review Group Membership** | |
| --- | --- |
| **Organisation / Sector Representation** | **Individual** |
| LCC – Children's Services |  |
| Clinical Commissioning Group representing Health Sector and Designate Doctor |  |
| Police |  |
| *Other agency with significant involvement* |  |
|  | |
| LSCP Business Manager |  |
| LSCP Legal Adviser |  |
| SIRG Chair (Rapid Review Panel Chair) |  |
| SIRG rep not involved in the case |  |

**Assumptions**

* All members will feed information back into their service, project, or organisation, and those they represent.
* All members will participate in the work of the Rapid Review Panel, whether directly or through identifying resources within their organisations.

**Changes to the Terms of Reference**

As the Rapid Review Panel develops, some changes may need to be made. Any changes will need to be authorised by the Rapid Review Panel.

**Approval**

|  |  |  |
| --- | --- | --- |
| **Date** | **Status** | **By** |
|  | Initial TOR Agreed | 3 Key Statutory Partners |
|  |  |  |

Appendix F - Chronology Template

| **Date** | **Source of Information** | **Agency/ Department** | **Name of Subject(s)** | **Type of Contact** | **By Whom?** | **Details of Event** | **Comments/Analysis of Outcome** |
| --- | --- | --- | --- | --- | --- | --- | --- |
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Appendix H – Practitioners’ Guide to Rapid Reviews

What is a Rapid Review?

When a local authority completes a notification to the National Panel, the local Safeguarding Children Partnership has a period of 15 working days to complete a review and produce a report. The review considers all partner information and involves a panel analysis of the practice and processes. High challenge is exercised in the panel meeting to ensure a thorough review and that learning is extracted in a timely and efficient manner. The review panel is chaired by the LSCP Serious Incident Review Group chair and advised by the LSCP Legal Advisor and Business Manager.

What triggers a Rapid Review?

There are two ways a Rapid Review can be triggered. The Local Authority has a duty to notify the National Child Safeguarding Practice Review Panel within five days of learning about a serious child safeguarding incident or whereby the LSCP Assurance Executive receives and agree with a recommendation to make a notification.

A serious child safeguarding incident is one whereby:

* Abuse or neglect of a child is known or suspected **and**
* The child has died or is seriously harmed.

Serious harm includes serious and/or long-term impairment of a child’s mental health or intellectual, emotional, social or behavioural development. It also covers impairment of physical health.

What is the purpose of a Rapid Review?

The purpose of RRs is to identify improvements to be made to safeguard and promote the welfare of children. They aim to create an understanding of whether and how policy and practice need to change. They are not about holding individuals or organisations to account.

How might a Rapid Review involve me?

The Rapid Review process involves all partners involved in an incident coming together to share information. A representative from your agency (Safeguarding Lead Officer—SLO) will compete a desktop review of the case records and complete a chronology of key events. Depending on the circumstances of the case, your SLO may need to speak to you to clarify some points and gain a greater understanding of some of the decisions and practice undertaken.

What are the outcomes from a Rapid Review?

The Rapid Review panel will convene and review all of the information provided about the incident. The panel members will write a report which will conclude with any learning points and recommendations.

The report also needs to make a recommendation to the National Panel about any further review—these could be either a Local or National Child Safeguarding Practice Review.

If you have been involved in the case, your SLO should speak to you and your manager about the outcomes from the review once it is concluded.

The reports are not made public and will not be shared with you, although learning for you will be fed back to you by your SLO and key learning generally from the review will be distributed from the LSCP and individual agencies.

Where can I find out more information?

There are a number of documents you can access to find out more on these processes:

[Working Together 2018](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf)

[Child Safeguarding Practice Review Panel: practice guidance April 2019](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793253/Practice_guidance_v_2.1.pdf)

LSCP Rapid Review Guidance

Alternatively, speak with your SLO.

Appendix I – Practitioners’ Guide to Local Child Safeguarding Practice Reviews

What is a LCSPR?

On completion of a Rapid Review (see appendix H) the report must conclude with consideration of any further review. Any review following a Rapid Review (RR) is considered a LCSPR and builds on the findings of the RR.

The LCSPR should be proportionate to the circumstances of the case, focus on potential learning and establish and explain the reasons why the events occurred as they did.

Safeguarding partners must ensure that:

* Practitioners are fully involved with the LCSPR
* Families, including surviving children are invited to contribute to the LSCPR.

The LSCP can determine the most suitable means to achieve this future learning

What triggers a LCSPR?

The criteria against which the Rapid Review panel will recommend a further review (LCSPR) is outlined in Working Together 2018.

* Highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
* Highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
* Highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.

Alternatively, the national panel may conclude that a LCSPR is appropriate.

What is the purpose of a LCSPR?

Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond. In order to achieve this, LCSPR reports are published. Even if issues appear to be similar to previous reviews, the reasons for the actions and behaviours may be different and so there may be different learning

How might a LCSPR involve me?

The focus will be on understanding practice and not to hold individuals or organisations to account.

Working Together 2018 promotes that “practitioners are fully involved in reviews and invited to contribute their perspective without fear of being blamed for actions they took in good faith”

How practitioners are involved may vary from review to review. You may be asked to meet with the author individually, feed information through your SLO or attend a practitioner event with colleagues involved with the child or family.

What are the outcomes from a LCSPR?

The final report must include:

* A summary of any recommended improvements to be made by individuals to safeguard and promote the welfare of children
* An analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report.

Any recommendations should be clear on what is required of relevant agencies and others collectively and individually, and by when, and focussed on improving outcomes for children.

Where can I find out more information?

There are a number of documents you can access to find out more on these processes:

* [Working Together 2018](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf)
* [Child Safeguarding Practice Review Panel: practice guidance April 2019](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793253/Practice_guidance_v_2.1.pdf)
* LSCP Review Guidance

Alternatively, speak with your SLO.

1. Working Together 2018: Chapter 4, paragraph 3-4 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf>

   [↑](#footnote-ref-1)
2. This National Panel refers to a body established in 2018 to oversee all Serious Child Safeguarding Reviews. [↑](#footnote-ref-2)
3. 16C (1) of the Children Act 2004 (as amended by the Social Work Act 2017) [↑](#footnote-ref-3)
4. <https://lincolnshirescb.proceduresonline.com/chapters/pr_prof_resolution.html> [↑](#footnote-ref-4)
5. [Working Together to Safeguard Children 2018 (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf) [↑](#footnote-ref-5)
6. <http://www.legislation.gov.uk/ukpga/2004/28/contents> [↑](#footnote-ref-6)
7. <https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-practice-guidance> [↑](#footnote-ref-7)
8. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793253/Practice_guidance_v_2.1.pdf> [↑](#footnote-ref-8)
9. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/624949/TheMunroReview-Part_one.pdf> [↑](#footnote-ref-9)
10. <https://lincolnshirescb.proceduresonline.com/chapters/pr_prof_resolution.html> [↑](#footnote-ref-10)
11. [Make a complaint – Before you make a complaint - Lincolnshire County Council](https://www.lincolnshire.gov.uk/comments-feedback/make-complaint) [↑](#footnote-ref-11)